STATE OF WYOMING
SUICIDE PREVENTION PLAN

Saving One Life

November, 2002

Suicide Prevention Task Force
Wyoming Department of Health

INTRODUCTION AND BACKGROUND

The devastating loss of human life by suicide and the accompanying grief, guilt, confusion and fear are all too familiar to many Wyoming families, friends, and communities. Suicide has always been a difficult topic to discuss. Although suicide involves multiple individual, social, and environmental factors, it is rarely random or inevitable. Suicide is a subject that is feared and misunderstood. However, through education, training, intervention, and treatment we can reduce the number of suicides within our state. SUICIDE IS PREVENTABLE in most cases.

The Surgeon General of the United States, in recognition that suicide is a national problem that is preventable, has declared suicide a serious public health issue. According to The Surgeon General's Call to Action to Prevent Suicide published in 1999, an average of 85 Americans die of suicide each day. Although more females than males attempt suicide, males are at least four times more likely to die of suicide. The majority of Americans who die from suicide suffer from a major mental illness and/or a substance abuse disorder. More than 60% of all people who die from suicide suffer from major depression (American Foundation for Suicide Prevention). Stigma associated with major mental illness prevents many persons from seeking help. It is estimated that 70% of individuals suffering from major depression in a given year do not seek help. (Suicide Awareness Voices of Education). Alcohol and/or other drugs are a factor in at least 30% of all completed suicides (American Foundation for Suicide Prevention).

Other factors that may be connected to suicide, particularly in western, rural states like Wyoming include the lack of family ties within the state; the physical isolation that many people in rural areas experience; the lack of a sufficient number of mental health professionals available to provide needed interventions; and the wide availability of firearms (Bill Briggs, Sunday Denver Post).

In Wyoming, the rate of suicide has historically been high and currently ranks fifth in the nation. With a rate of 16.8 per 100,000 population, our suicide rate is 63% higher than the national rate of 10.6 per 100,000 population.[1] Suicide is the 9th leading cause of death within the State. In Wyoming, we lose approximately 90 lives to suicide each year. Based on a life expectancy of 75 years, approximately 2,525 years of potential life were lost to suicide in Wyoming in 2000. A firearm was used in 60% of all suicides in the state. (Wyoming Vital Statistics, 2000).

Suicide affects all age ranges. Nationally, suicide is the 4th leading cause of death among children 10-14 years of age. The suicide rate for this age group has increased 100% between 1980 and 1996 (Center for Disease Control). Children as young as 9 have ended their lives by suicide in Wyoming.

The national incidence of suicide among youth age 15 - 24 years old has tripled in the last 40 years. More teenagers and young adults die of suicide than from cancer, heart disease, birth defects, and other illnesses combined (U.S. Public Health Service, 1999). There are an estimated 100 - 200 suicide attempts for every death by suicide among this age group (American

Association of Suicidology). Among youth, age 15 -24 years, suicide is the second leading cause of death in Wyoming, following unintentional injuries (Wyoming Vital Statistics, 2000). According to the 2001 Wyoming Youth Risk Behavior Survey conducted for the State Department of Education, 18.5% of high school students surveyed reported they considered attempting suicide during the twelve months prior to the survey. Twenty-two percent of middle school students reported they had thought about killing themselves. Seven percent of high school students surveyed and 9% of middle school students surveyed indicated they had actually attempted suicide one or more times during the 12 months preceding the survey. In addition to major mental illnesses and substance abuse, family histories of abuse, and violence are risk factors in teen suicide, as are unplanned pregnancies, runaway behavior and incarceration. Research has suggested that gay and lesbian youth are at high risk of suicide, however, no definitive studies have been conducted. Examination of this issue is complicated by the lack of accurate information on the rate of homosexuality nationally and by the conflicts generated by the topic. Suicide among youth is often an impulsive act.

Suicide is not only a problem among our youth. Wyoming statistics for 2000 indicate that suicide was the second leading cause of death for adults age 25-44. Persons aged 25 - 55 accounted for 60% of suicides (Wyoming Vital Statistics, 2000). Research indicates that there are approximately 25 suicide attempts among adults for every death by suicide (American Association of Suicidology). Using this estimate, there were approximately 1,250 suicide attempts among Wyoming adults in this age group during the year 2000.

Nationally, suicide rates increase with age and are highest among Americans 65 years of age and older (U.S. Public Health Service, 1999). In general, mental health and substance abuse issues are not identified in the elderly or may be disguised by medications. Risk factors such as physical illness, death of a partner or friends, economic problems and lack of social support are often discounted as a fact of "growing old". Depressive illnesses are major risk factors for suicide in the elderly (Centers for Disease Control). "Passive suicide" in which the older adult may stop eating or stop using medication is not uncommon. The elderly are the most likely to have visited a physician shortly before their suicide, providing an opportunity for intervention. During 2000 in Wyoming, persons age 55 and older who died by suicide represented 25% of all suicides. (Wyoming Vital Statistics, 2000).

White males and white females account for more than 90% of all suicides (Centers for Disease Control). According to the National Center for Health Statistics, suicide rates are lowest among blacks and nonwhite (Hispanic and Asian) Americans. In 2000, the suicide rate among blacks was 5.6 per 100,000 population and among nonwhite the rate was 5.9 per 100,000 population. However, suicide rates for Native Americans (a category which includes American Indians and Alaskan Natives) are higher than national rates. Youth age 15 -24 have the highest rates among Native Americans, with an overall age-adjusted rate of 19.2 per 100,000 population (Middlebrook, 2000). Among Native Americans, suicide rates peak during the teen and early adult years and decrease around age 40 (Wyche and Rotheram-Borus, 1990). Cultural factors, unemployment, poverty, mental illness and use of substances, particularly alcohol, are risk factors for suicide among Native Americans.

Suicide among young Hispanics is a growing concern. In one study, over 13% of Hispanic high school students reported making at least one suicide attempt in the year prior to the study, compared to 8.9% of non Hispanic blacks and 7.8% of non Hispanic whites (National Alliance

for Hispanic Health, 2000). Hispanic girls, in particular, are at high risk for suicide. The reported creation of a suicide plan and a suicide attempt requiring medical attention is highest among Hispanic female students (Tienda and Kleykamp, 2000). According to a report from the National Alliance for Hispanic Health, one in three Hispanic girls has seriously considered suicide. This rate is the highest of any racial or ethnic group of the same age. The stressors of minority group status in combination with low self esteem, and depression faced by many adolescents, are thought to be contributing factors to the escalating rate of suicide among female Hispanic youth (Tienda and Kleykamp, 2000).

Suicide is the leading cause of death among inmates in jails, where more than 400 inmates per year take their own lives (Hayes and Rowan, 1988). Among jail inmates, the rate of suicide is approximately 9 times greater than in the general population (Hayes, 1995). According to a study conducted in 1999 by the Bureau of Justice Statistics, 16% of prison inmates across the United States are mentally ill. Although the rate of suicide in prisons is far lower than that in jails, the rate is disproportionately higher than in the general population (Hayes, 1995).

As alarming as these statistics are, research indicates that the scope of the problem is much larger than data indicate. The societal, religious, and cultural taboos against suicide affect the accuracy of reporting. Suicides are often listed as accidental deaths, overdoses, or other less stigmatized occurrences (Gibbs, 1988). Real and perceived stigma create pressure from families to label suicide as accidental or undetermined deaths (Wyche and Rotheram-Borus, 1990). Negative consequences involved with insurance claims, settlement of estates, workers' compensation claims and individual reputations all compound and encourage the under reporting of suicides (Ivanoff & Riedel, 1995). Oftentimes, as in the case of automobile accidents, suicides are not distinguishable as such. Intentional or not, under reporting of suicides is estimated to range from 10% (Kleck, 1988) to 33% (Dublin, 1963).

SUICIDE PREVENTION TASK FORCE

The Wyoming Department of Health established the Suicide Prevention Task Force in response to the growing public health concern over suicide, the probability that the rate is higher than reported, and in accordance with the national agenda. The Task Force is a multi-disciplinary coalition whose members represent both public and private sectors, families, and individuals touched by suicide. The mission of the Task Force is to improve the health and wellness of Wyoming citizens over the life span by reducing suicide and its impact on individuals, families, and communities.

The Task Force has researched risk factors related to suicide among youth, identified and reviewed numerous educational and intervention approaches that may impact youth suicide, and identified barriers to prevention and early intervention. In 1998 the Task Force conducted a statewide survey of suicide prevention activities in all Wyoming school districts.

Following the lead of the Suicide Prevention Advocacy Network (SPAN) and the national conference on suicide held in Reno Nevada in 1998, the Task Force planned and organized the first statewide conference on suicide, held in January 2000. The conference utilized national and regional experts on the topic of suicide, with emphasis on the elderly, youth, and Native Americans. The 211 participants were welcomed by Governor Jim Geringer and included

representatives from various human service agencies, health care providers, school personnel, law enforcement, legislators, clergy, families and survivors of suicide.

Following the conference, the efforts of the Task Force focused on the development of a statewide Suicide Prevention Plan. Members of the Task Force collected and reviewed suicide prevention plans developed by other states, as well as the National Suicide Prevention Strategy Draft Goals and Objectives.

The Task Force has developed brochures and public service announcements that have been broadcast on Wyoming radio and TV stations to increase public awareness about suicide and provide information on suicide risk. A Gatekeeper Training for community members was created by Task Force members and has been provided to over 300 people since its development in late 2001. The training provides information and education on suicide and mental illnesses and gives attendees tools to use when faced with someone at risk of suicide.

Through the Wyoming Department of Health, Mental Health Division, the Task Force has funded six communities to develop community coalitions on suicide prevention, conduct needs assessments, and provide suicide prevention activities. Funding has also been made available to four counties to provide education, training and consultation to primary care physicians on identifying and assessing mental illness and suicide risk.

Currently the Task Force is planning a second conference on suicide prevention scheduled in May of 2003. The conference will combine state and national experts to share information and provide tools that will assist in preventing suicide.

GUIDING PRINCIPLES

In developing the Plan, the Suicide Prevention Task Force adopted the following GUIDING PRINCIPLES:

1. Suicide is preventable.

2. Suicide is a serious public health problem. A public health approach* to suicide prevention will maximize efforts and resources.

3. A sustained, long-term commitment is required to reduce suicide rates.

4. The statewide plan must be considered in its entirety; piecemeal implementation may not be effective.

5. Suicide is interrelated with other social complexities and cannot be impacted in isolation.

6. A comprehensive response to suicide requires a continuum of services, i.e., prevention, intervention, post-intervention and treatment.

7. Suicide prevention and intervention activities must build on the strengths of individuals, families and communities.

8. The development of healthy communities through comprehensive, collaborative community-based approaches is required in order to reduce the rate of suicide.

9. Suicide prevention and intervention approaches should be culturally competent, should reflect community values and should be age appropriate.

10. Planning and implementation of suicide prevention and intervention activities should include the participation of individuals within the target population as well as survivors and families.

11. Suicide prevention/intervention activities must be outcome based and include rigorous evaluation components. be effective.

* The public health approach focuses on identifying and understanding patterns of suicide and suicidal behavior throughout a group or population. The public health approach defines the problem, identifies risk factors and causes of the problem, develops interventions evaluated for effectiveness and implements such intervention widely in communities. Although this description suggests a linear progression from the first step to the last, in reality, the steps occur simultaneously and depend on each other. (U.S. Public Health Service, 1999.)

PRIORITY ACTIVITIES NECESSARY TO IMPLEMENT THE PLAN AND ITS STRATEGIES

1. The establishment of a lead entity within the Wyoming Department of Health to ensure a coordinated approach to suicide prevention statewide is viewed as essential to the successful implementation of this plan. The lead entity should have the authority, responsibility and funding to effectively implement and evaluate the plan. Sustained funding, to include full time staff positions and necessary support services, will ensure a comprehensive response over time. In collaboration with the Suicide Prevention Task Force, the lead entity will establish best practice guidelines for suicide prevention and intervention, provide leadership, point of contact, consultation, technical assistance, data collection, systems development, and collaboration with regional and national suicide prevention efforts.

2. Responsibility for local implementation of the Suicide Prevention Plan must reside in communities, through existing or new community groups or other local partnerships. Building on the unique strengths and resources of each community, local groups should operate with assistance from, and in collaboration with, the state's lead entity.

3. Strengthening existing and establishing new public/private partnerships will advance implementation of Wyoming's Suicide Prevention Plan. Utilizing a variety of existing services and resources in a coordinated/cooperative effort will maximize community and statewide efforts to prevent suicide and enhance the value and joy of living.

WYOMING'S SUICIDE PREVENTION TASK FORCE RECOMMENDED SUICIDE PREVENTION STRATEGIES

These recommendations are guided by The Surgeon General's Call to Action to Prevent Suicide and the National Suicide Prevention Strategy Draft Goals and Objectives. Just as The Surgeon General's Call to Action is a blueprint for states to develop their own plans, this statewide plan is designed as a blueprint for communities to develop and implement research-based suicide prevention approaches that address their own unique community needs.

GOAL: REDUCE THE RATE OF SUICIDE IN WYOMING AMONG ALL AGE GROUPS AND CULTURES

OBJECTIVE 1. AWARENESS: Promote education and training designed to increase the public's awareness of suicide and its risk factors.

Potential sources of measurement data include but are not limited to: the number of education and training opportunities provided; the number of media reports made available; and the numbers of letters of support received.

Method 1.1 Provide ongoing public education and training on suicide and its risk and protective factors to reduce the confusion and fear associated with suicide, increase the public's knowledge of suicide prevention, and promote help-seeking behaviors.

Method 1.2 Provide education to state, county, and local officials, including judges and court personnel, about suicide, suicidal behavior, mental illness and substance abuse and the associated impact on health care, social services, law enforcement, employment, corrections systems, etc.

Method 1.3 Develop partnerships with the media to facilitate publication and dissemination of information on suicide and its risk and protective factors.

Method 1.4 Establish broad-based support by distributing Wyoming's Suicide Prevention Plan to stakeholder groups, private entities, professionals and the general public.

OBJECTIVE 2. INTERVENTION: Increase access to and utilization of population-based and clinical services and programs

Potential sources of measurement data include but are not limited to: community mental health centers; hospitals, senior citizen centers, and suicide prevention programs.

Method 2.1 Implement research-based suicide prevention programs in communities and schools statewide which focus on individual, family and community risk and protective factors and best practices.

Method 2.2 Coordinate with the National Crisis Intervention Hotline to extend coverage and connect with in-state referral sources throughout Wyoming.

Method 2.3 Provide education and training on suicide prevention to families and significant others whose loved ones are at risk of suicide.

Method 2.4 Provide training for community helpers, such as school bus drivers, mail carriers, meter readers, taxi drivers, coaches, hairdressers, animal control officers, Meals on Wheels volunteers, senior service volunteers and faith leaders on how to recognize, respond to, and refer for help, people at risk of suicide and associated mental and substance abuse disorders.

Method 2.5 Provide course work on suicide and associated mental illnesses and substance abuse as a required component of higher education for human service professionals.

Method 2.6 Provide training on suicide risk assessment and recognition, management, and aftercare interventions as a recommended requirement for certification/licensure or continued certification/licensure of law enforcement officers, dispatchers, correctional facility personnel, mental health and substance abuse professionals, psychologists, nurses, physicians, emergency medical technicians and other health related occupations.

Method 2.7 Train emergency room personnel to routinely assess and refer to mental health services, for example, individuals who have experienced psychological trauma such as physical or sexual abuse or suicide attempts.

Method 2.8 Establish the availability of depression screening in primary health care settings.

Method 2.9 Provide training to primary health care providers on how to recognize and refer for treatment, individuals with depression, other major mental illnesses and substance abuse.

Method 2.10 Provide periodic in-service training for educators and school personnel on recognizing the signs and risk factors of suicide and how to facilitate appropriate interventions.

Method 2.11 Provide an adequate ratio of mental health professionals to students in each school, college and university.

Method 2.12 Provide mental health services in schools, independent of school guidance functions, special education functions, testing functions, etc.

Method 2.13 Establish a crisis response management plan to include suicide intervention and postvention activities in each school, college and university.

Method 2.14 Provide funding for adequate programming and staffing of community mental health service systems to provide best practice of care within a continuum of care.

Method 2.15 Establish mental health parity in insurance coverage.

Method 2.16 Develop strategies to improve access to psychotropic medications.

Method 2.17 Provide access to mental health and substance abuse services in homeless shelters, correctional programs, group care facilities, nursing homes, youth crisis centers and foster care.

Method 2.18 Promote and encourage safe storage of firearms, medications, and toxic substances and the use of trigger locks.

Method 2.19 Partner with the media on the reporting and portrayals of suicidal behavior, mental illness and substance abuse to minimize sensationalism and reduce the chances of cluster suicides, in accordance with the media guidelines developed by the American Association of Suicide and Centers for Disease Control and Prevention.

OBJECTIVE 3. Methodology: Advance the science of suicide prevention.

Potential sources of measurement data will be available through coordination of suicide data with other western rural states; and collaborations between the Wyoming Department of Health, Department of Education, Department of Family Services, public and private agencies, and advocacy groups.

Method 3.1 Establish long-term research studies on the risk factors for suicidal behaviors. Include as one component of the research, post-intervention follow-up studies on all completed suicides to determine the characteristics of persons involved, circumstances of the incidents and events which may have precipitated the act, and the adequacy of any support or health services received. This data can be used to provide feedback on risk factors in Wyoming and will aid the development of comprehensive prevention and intervention approaches.

Method 3.2 Standardize the collection and reporting of suicides and suicide attempts by state and local authorities.

Method 3.3 Develop an ongoing evaluation component for each prevention and intervention strategy implemented.

SUICIDE RISK AND PROTECTIVE FACTORS

RISK FACTORS

Understanding risk factors can help dispel the myths that suicide is a random act or results from stress alone. Some persons are particularly vulnerable to suicide and suicidal self-injury because they have more than one mental disorder present, such as depression with alcohol abuse. They may also be very impulsive and/or aggressive, and use highly lethal methods to attempt suicide. The importance of certain risk factors and their combination vary by age, gender, and ethnicity.

The impact of some risk factors can be reduced by interventions. Those risk factors that

cannot be changed (such as a previous suicide attempt) can alert others to the heightened risk of suicide during periods of recurrence of a mental or substance abuse disorder, or following a significant stressful life event.

Risk factors include:

- Previous suicide attempt
- Mental disorders, particularly mood disorders such as depression and bipolar disorder
- Co-occurring mental and alcohol and substance abuse disorders
- Family history of suicide
- Threats of suicide
- Hopelessness
- Impulsive and/or aggressive tendencies
- Barriers to accessing mental health treatment
- Relational, social, work, or financial loss
- Physical illness
- Easy access to lethal methods, especially guns
- Unwillingness to seek help because of stigma attached to mental disorders, substance abuse disorders, and/or suicidal thoughts
- Influence of significant people - family members, celebrities, peers who have died by suicide - both through direct personal contact or inappropriate media representations
- Cultural and religious beliefs - for instance, the belief that suicide is a noble resolution of a personal dilemma
- Local epidemics of suicide that have a contagious influence
- Isolation, a feeling of being cut off from other people

Adverse life events in combination with other strong risk factors such as mental or substance abuse disorders and impulsivity, may lead to suicide. However, suicide is not a normal response to the stresses experienced by most people. Many people experience one or more risk factors and are not suicidal.

PROTECTIVE FACTORS

Protective factors can include an individual's genetic or neurobiological makeup, attitudinal and behavioral characteristics, and environmental attributes. Measures that enhance resilience or protective factors are as essential as risk reduction in preventing suicide. Positive resistance to suicide is not permanent, so programs that support and maintain protection againt suicide should be ongoing.

Protective factors include:

- Effective and appropriate clinical care for mental disorders, physical disorders, and substance abuse disorders.
- Easy access to a variety of clinical interventions and support for help seeking.
- Restricted access to highly lethal methods of suicide.
- Family and community support.
- Support from ongoing medical and mental health care relationships.
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes.
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts.

Source: U.S. Public Health Service, *The Surgeon General's Call to Action to Prevent Suicide.* Washington, D.C.: 1999.

References

American Association of Suicidology. (Online). Available: http:// www.suicidology.org

American Foundation for Suicide Prevention. (Online). Available: http:// www.afsp.org

Briggs, B. (2000) *Isolation, access to guns tied to West's soaring rate.* Sunday Denver Post.

Bureau of Justice Statistics (1999). *Special report on mental health and treatment of inmates and probationers*. Washington, D.C.: U.S. Department of Justice.

Centers for Disease Control and Prevention. (Online). Available: http:// www.cdc/gov

Dublin, L. (1963). *Suicide: a sociological and statistical study*. New York: Ronald Press.

Gibbs, J.T. (1988). *Conceptual, methodological and sociocultural issues in black youth suicide: implications for assessment and early intervention.* Suicide and Life Threatening Behavior, 18:73-89.

Hayes, L. (1995). *Prison suicide: an overview and guide to prevention.* Alexandria, VA: National Center on Institutions and Alternatives, Sponsored by the National Institute of Corrections, U.S. Department of Justice.

Hayes, L. and Rowan, J.R. (1988). *National study of jail suicides: seven years later*. Alexandria, VA: National Center on Institutions and Alternatives, Sponsored by the National Institute of Corrections, U.S. Department of Justice.

Ivanoff, A. and Riedel, M. (1995). *Suicide*. In R.L. Edwards and J.G. Hopps (eds), *Encyclopedia of Social Work* 19:2358-2372. Washington, D.C. NASW Press.

Kleck, G. (1988). *Miscounting suicides.* Suicide and Life-Threatening Behavior, 18:219:236.

Middlebrook, D.L. (2000). *Suicide prevention in American Indian and Alaska Native communities: a critical review of programs.* Draft version not in print.

Minnesota Department of Health, Family Health Division (2000). *Report to the Minnesota legislature: suicide prevention plan.*

National Alliance for Hispanic Health (2000). *Quality health services for Hispanics: the cultural competency component.* Special Education Guide. Department of Health and Human Services Office of Minority Health, Substance Abuse and Mental Health Services Administration.

Silverman, M. and Maris, R. (1995). *Suicide prevention toward the year 2000.* New York: Guilford Press.

Suicide Awareness Voices of Education. (Online). Available: http:// www.save.org

Tienda, M. and Kleykamp, M. (2000). *Physical and mental health status of Hispanic adolescent girls: a comparative perspective*. Office of Population Research, Princeton University.

U.S. Public Health Service(1999). *The surgeon general's call to action to prevent suicide*. Washington, D.C.

U. S. Public Health Service (2000). *The national suicide prevention draft goals and objectives.* Washington, D.C.

Wyche, K.F. and Rotheram-Borus, M.J. (1990). *Suicidal behavior among black youth in the United States*. in A.R. Stiffman & L.E. Davis (eds). *Ethnic issues in adolescent mental health*: 323-338. CA: Sage Publications.

Wyoming Department of Education. (1999). *1999 youth risk behavior survey*. Cheyenne, Wyoming.

Wyoming Department of Health. (1999). *Wyoming vital statistics, 2000.* Cheyenne, Wyoming.